

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Lillian Larrimore		COMEY S		May 19, 1984		1:50 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
Female		White		August 5, 1902		81 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Queen Anne's		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Centreville		Nursing Center/Corsica Hills		Wife		Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN			
Maryland				Queen Anne's		Queenstown			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Charles Edmon Larrimore				Frances O'Della Hopkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		217-30-9269		Daughter		2nd. Street			
				Mrs. Ann C. Anthony, Queenstown, Md.		21658			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2500 IMMEDIATE CAUSE (a)								10 years	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
Hereditary Vas. Dis. Senile Changes								5 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1964, to May 19, 1984, that (I) (we) lost saw the deceased alive on May 19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				DATE SIGNED	
John R. Smith, Jr.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				5/25/84	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
John R. Smith, Jr., M.D.				Centreville, Md. 21617					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		May 22, 1984		Chesterfield Cemetery		Centreville, Q.A.Co. Md.			
24. FUNERAL DIRECTOR NAME		Barton Funeral Home		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James H. Barton, Jr., Centreville, Md. 21617				MAY 25 1984		John R. Smith, Jr.			



INDEX

1. Name of the person  
2. Address  
3. Date of birth  
4. Date of death  
5. Date of marriage  
6. Date of divorce  
7. Date of remarriage  
8. Date of remarriage  
9. Date of remarriage  
10. Date of remarriage

11. Name of the person  
12. Address  
13. Date of birth  
14. Date of death  
15. Date of marriage  
16. Date of divorce  
17. Date of remarriage  
18. Date of remarriage  
19. Date of remarriage  
20. Date of remarriage

21. Name of the person  
22. Address  
23. Date of birth  
24. Date of death  
25. Date of marriage  
26. Date of divorce  
27. Date of remarriage  
28. Date of remarriage  
29. Date of remarriage  
30. Date of remarriage

31. Name of the person  
32. Address  
33. Date of birth  
34. Date of death  
35. Date of marriage  
36. Date of divorce  
37. Date of remarriage  
38. Date of remarriage  
39. Date of remarriage  
40. Date of remarriage

41. Name of the person  
42. Address  
43. Date of birth  
44. Date of death  
45. Date of marriage  
46. Date of divorce  
47. Date of remarriage  
48. Date of remarriage  
49. Date of remarriage  
50. Date of remarriage

51. Name of the person  
52. Address  
53. Date of birth  
54. Date of death  
55. Date of marriage  
56. Date of divorce  
57. Date of remarriage  
58. Date of remarriage  
59. Date of remarriage  
60. Date of remarriage

61. Name of the person  
62. Address  
63. Date of birth  
64. Date of death  
65. Date of marriage  
66. Date of divorce  
67. Date of remarriage  
68. Date of remarriage  
69. Date of remarriage  
70. Date of remarriage

71. Name of the person  
72. Address  
73. Date of birth  
74. Date of death  
75. Date of marriage  
76. Date of divorce  
77. Date of remarriage  
78. Date of remarriage  
79. Date of remarriage  
80. Date of remarriage

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14615

1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 20 1984										2b. HOUR 9:55 AM			
3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Danny Richard Downes										7c. DATE PRONOUNCED DEAD 5 20 1984										7d. HOUR 9:55 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 1 63		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7e. DATE PRONOUNCED DEAD 5 20 1984										7d. HOUR 9:55 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County, MD											
10. CITY OR TOWN OF DEATH Ingleside				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O. Box 12, Rt. 19				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Black & Dedler											
13a. STATE Maryland				13b. COUNTY Queen Anne's		13c. CITY OR TOWN Ingleside		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 12 21644													
14. FATHER'S NAME FIRST MIDDLE LAST Thomas H. Downes, Sr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Ann Thorpe																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 220-84-6506		17. INFORMANT ADDRESS Doris Ann Downes Ingleside, MD															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9551 IMMEDIATE CAUSE (b) Shotgun wound of head DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5 20 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION CITY OR TOWN P.O. Box 12, Rt. 19, Ingleside, Queen Anne's, Md. STATE MD															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				Margarita A. Korell, M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 5/21/84											
EXAMINER'S NAME (TYPE OR PRINT)				111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial				23b. DATE 5-23-84		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery				23d. LOCATION CITY OR TOWN Greensboro COUNTY CA STATE MD													
24. FUNERAL DIRECTOR NAME John E. Boulos ADDRESS Greensboro				25a. DATE RECD. BY REGISTRAR MAY 25 1984				25b. REGISTRAR'S SIGNATURE Julia Davidson-Pondelle															

No	250-84-6506	Doris Ann Downes	Ingleside, MD
Thomas	H. Downes, Sr.	Doris Ann	Thorpe
Maryland	Queen Anne's Ingleside	X	P.O. Box 12
			21644
		Laborer	Black & Decker
Maryland	USA		
Male	White	10 1	63 20
			X

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8414616  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN MILLER HEADLEE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>5-17-84</b>			2b. HOUR <b>4:26a</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 30 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TEXAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>QUEEN ANNE</b> MD.				
10. CITY OR TOWN OF DEATH <b>CENTREVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING CENTER COCKSIA HILLS</b>				12a. USUAL OCCUPATION (LIFE OF WORK OR MOST OF WORKING LIFE) <b>SHOE REPAIR BUS.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHOE</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>QUEEN ANNE</b>		13c. CITY OR TOWN <b>CENTREVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>ROUTE 213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ARCHIE LEE MILLER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CORA JANE BLASSINGAME</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>453-17-5126</b>			17. INFORMANT <b>JANE BUTTRILL</b>			ADDRESS <b>1616 MEETING HOUSE LN ANNAPOIS MD 21401</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <b>4292 Uremia</b> DUE TO, OR AS A CONSEQUENCE OF (b): <b>ascu</b> DUE TO, OR AS A CONSEQUENCE OF (c):								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>5 yrs.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/17/84</b> , 19 <b>84</b> , to <b>May 17</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>May 17</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)										
22b. SIGNATURE <b>JR Amick</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/17/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Smith Jr</b>			22e. ADDRESS <b>Centreville Md 21617</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>5-21-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>TEAGUE FREESTONE 6 TEXAS</b>			
24. FUNERAL DIRECTOR NAME <b>Taylor Funeral Chapel</b>			ADDRESS <b>ANNAPOIS MD</b>			25a. DATE REC'D. BY REGISTRAR <b>MAY 24 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use in the burial-transit permits. Then please remove carbon papers. Pages 1 and 2 should be filed with 7 copies after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "I", it shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 84 14617			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <i>James Webster Kimble</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>May 4, 1984</i>		2b. HOUR <i>7:00 p.m.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 31 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Queen Anne's Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Church Hill</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>at his home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Q.A.</i>		13c. CITY OR TOWN <i>Church Hill</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Charles Kimble</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Elizabeth Payne</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-40-8729</i>	
17. INFORMANT ADDRESS <i>Georgianna Minch Kimble, Church Hill, Md</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ca of Prostate c metastases</i> 1850		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-16</i> , 19 <i>76</i> , to <i>5-4</i> , 19 <i>84</i> , that (I) (we) lost <i>5-4</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John R. Smith Jr</i>		DEGREE		22c. DATE SIGNED <i>5/7/84</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John R. Smith Jr</i>		22e. ADDRESS <i>Centerville MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>05/07/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Church Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Church Hill Q.A. MD</i>	
24. FUNERAL DIRECTOR NAME <i>Tom Helfenbein</i>		ADDRESS <i>Funeral Home, Chester, Md.</i>		25a. DATE RECEIVED BY REGISTRAR <i>MAY 14 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 84 14618			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 5 26 84			
1. DECEASED NAME (TYPE OR PRINT) George Wesley Ringrose				2b. HOUR 5 20 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 20, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County MD.	
10. CITY OR TOWN OF DEATH Chester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at his home - Rt. 1 Box 511		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad Carman		12b. KIND OF BUSINESS OR INDUSTRY B. & O.	
13a. STATE Maryland		13b. COUNTY Q.A.		13c. CITY OR TOWN Chester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Ringrose		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Kelly		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 212-09-1240		17. INFORMANT ADDRESS Daisy C. Ringrose, Chester, MD 21619					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Metastatic Carcinoma: Lung primary noncatal				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Brain metastasis							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/31, 19 83, to 12/31, 19 84, that (I) (we) last saw the deceased alive on March 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Marvin J. Feldman				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARVIN J. FELDMAN MD				22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05/30/84		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Stevensville Q.A. MD	
24. FUNERAL DIRECTOR NAME Tom Helfenbein				ADDRESS Stevensville, MD		25a. DATE REC'D. BY REGISTRAR JUN 6 1984	
				25b. REGISTRAR'S SIGNATURE		J. Davidson-Randall	

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*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines of text, possibly a list or a document body, spanning the width of the page.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 4 per ph. 5/23/84 kg

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8414619  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Edwin TURNER, Sr.			2a. DATE OF DEATH MONTH DAY YEAR May 10, 1984		2b. HOUR 2:45 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 8, 1914	6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's MD.		
10. CITY OR TOWN OF DEATH Centreville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) residence, Oak Street, P.O. Box 322		12a. USUAL OCCUPATION Resident Maintenan ance Engineer (retired)	12b. KIND OF BUSINESS OR INDUSTRY Maryland State Roads	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Queen Anne's	13c. CITY OR TOWN Centreville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Charles Bascum Turner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Susanna Green		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-34-7557	17. INFORMANT Wife ADDRESS Oak St., P.O. Box 322 Mrs. Frances C. Turner, Centreville, Md. 21617		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVA 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive C-V D's DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 8, 1962, to May 10, 1984, that (I) (we) lost saw the deceased alive on Apr. 29, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (shall) (will) view the body after death.					
22b. SIGNATURE John R. Smith, Jr., M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr., M.D.		22e. ADDRESS Centreville, Md. 21617			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 13, 1984	23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A.Co., Md.	
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617		25a. DATE REC'D. BY REGISTRAR MAY 15 1984 25b. REGISTRAR'S SIGNATURE John Swinden-Rodale			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HORACE - WALKER					2a. DATE OF DEATH MONTH DAY YEAR 5 28 84				
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 1 - 1 - 93		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		7b. HOUR 10 <sup>15</sup> AM	
7a. BIRTHPLACE (CITY OR TOWN) OR FOREIGN COUNTRY WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH QUEEN ANNE MD.			
10. CITY OR TOWN OF DEATH CENTREVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - Corsica Hills Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm laborer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY md. Kent					13b. CITY OR TOWN Millington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS SANDFIELD RD. 21645
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 217-30-8794		17. INFORMANT ADDRESS Helen Hafberg millington, Md. 21645		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 4100 IMMEDIATE CAUSE (a) Possible Acute Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Possible Acute Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Patrick Molony					DEGREE M.D.			22c. DATE SIGNED 5/31/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK MOLONY MD					22e. ADDRESS MEDICAL BLDG CHESTERTOWN, MD 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5/31/84		23c. NAME OF CEMETERY OR CREMATORY MT. PLEASANT CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE POND TOWN, Q.A. MD		
24. FUNERAL DIRECTOR FELLOWS F.H. BOX 270 MILLINGTON, MD 21645					25a. DATE REC'D. BY REGISTRAR JUN 01 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

